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Session 54 ›› 3:15-3:45 pm ›› Salon H

Mental Health Communication Training for Pediatric Primary Care Providers: Impact on Disparities

Presenting: Jonathan Brown & Lawrence Wissow
Contributing: Anne Gadomski

Introduction

Pediatric primary care providers (PCPs) play an integral role in the system of care for children with mental health needs. Often the first health professionals to identify mental health problems in children, PCPs are one of the gateways to mental health specialists and, for many children, they are the only source of mental health services (Farmer et al., 2003; Horwitz et al., 1998).

However, child mental health problems are often not discussed during primary care visits (Garrison et al., 1992). Communication about mental health may be particularly poor with minority families, who may have negative perceptions of mental health services (Gary, 2005; Bailey & Owens, 2005) or use terminology unfamiliar to the PCP to describe mental health concerns (Guarnaccia, 2005). The resulting gaps in communication may explain why many minority children with mental health needs either do not receive services (Kataoka et al., 2002) or receive them later than their Caucasian counterparts (Hough et al., 2002). Improving PCPs' communication with minority families about mental health may increase the extent to which emerging problems are identified and impairment is prevented, especially among minority youth.

This presentation reports the child and parent outcomes of a brief training for PCPs to improve communication with families about child mental health; also discussed is whether the training differentially improved the mental health status of minority youth.

Methods

The training involved three hour discussions with a child psychiatrist structured around videos of providers demonstrating mental health communication skills, each followed by practice session with standardized patients and self-evaluation. PCPs learned to encourage parents and children to discuss mental health, partner with families to understand the context of problems and agree on treatment, and increase expectation that treatment would help. Training was tested at 13 sites throughout rural New York, urban Maryland, and Washington, DC. Providers were randomized within site to receive training. Children 5-16 years old making routine visits were enrolled into the follow-up evaluation if they screened "possible" or "probable" for mental disorder according to the parent-reported Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1999) or if the PCP identified the child as having a mental health problem. Families were then followed for six months to assess the change in child mental health (SDQ) and in parent emotional distress (General Health Questionnaire)(Goldberg & Hillier, 1979). Generalized estimating equations (GEE) were used to examine the difference in the change in parent and child outcomes between the treatment and control group. Statistical interactions tested whether outcomes were differentially associated with the child's race and ethnicity.

Results

Fifty-eight providers (31 trained and 27 controls) and 418 children (248 patients of trainees and 170 patients of controls) participated. Eighty-eight percent (*n* = 367) were followed for 6 months after the training. The SDQ identified 72% of children in the six-month follow-up as having a mental health problem. Fifty-four percent were non-Latino Caucasian, 30% non-Latino African-American, 12% Latino, and 4% other race/ethnicity. There was a greater reduction of mental health impairment among minority children who were patients of trained PCPs compared with those who were patients of control PCPs (Δ = -0.91 points, 95% CL .-1.8 to -0.01). Parents of children who visited a trained PCP experienced a greater reduction in emotional distress than parents of children who visited a control PCP regardless of race/ethnicity (Δ = -1.7 points, 95% CL –3.2 to -.11).

Conclusion

Brief communication training for PCPs reduced both parent emotional distress and minority children's mental health impairment across a range of problems. The training may have differentially reduced impairment among minority children because PCPs acquired skills to help families clarify their mental health concerns and tailor treatment to family preferences, which differ according to race/ethnicity (Pumariega et al., 2005). Trained PCPs may have been able to increase minority parents' trust in the helpfulness of treatment (Richardson, 2001).

Broad-based communication training may complement interventions focused on specific disorders and may facilitate the reduction of disparities. This type of training may improve cultural competence in a manner that does not stereotype treatment according to race or ethnicity. Instead, the training helps PCPs understand families' perspectives on mental health problems and their treatment preferences.

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Session 55 ›› 2:45-3:15 pm ›› Salon I
A Large Scale Needs Analysis Based on Statewide Quantitative and Qualitative Data

Presenting: Ryan M. Quist

Introduction

Family involvement and interagency collaboration are key components of Children's Systems of Care (U.S. Public Health Service, 2000). Family input is important at all levels of system delivery and throughout the administrative and managerial decision-making processes (Jivanjee & Robinson, 2007). Collaboration between various agencies serving the Children's Mental Health client population is necessary for advancing and promoting continuity of care. Promotion of children's mental health must involve agencies such as schools, the juvenile justice system, social services, and physical health care providers (Morrissey, Johnsen & Calloway, 1997).

In California, the Children's System of Care is experiencing an evolutionary leap forward, and the planning process for these advances is based on intensive feedback from a broad range of key stakeholders. In November, 2004, a community initiated proposal was approved by California's voters referred to as the Mental Health Services Act (MHSA), which allocated over $250 million for community mental health services during its first year. In addition to generating funds, the proposition explicitly specified an intensive planning process driven by consumers and community stakeholders. With an emphasis on meeting localized community needs, California's counties were required to submit proposals for how the funds would be used and the proposals were required to specify how consumers and community stakeholders contributed to the development of the plans.

Recovery Instead of Medicaid

To briefly describe the rather complex but well-defined MHSA legislation, funds from a 1% tax on all individuals with an annual income of $1 million or more will go to (1) Community Planning, (2) Community Services and Supports, (3) Prevention and Early Intervention, (4) Innovative Programs, (5) Capital Facilities and Technology, and (6) Education and Training for the mental healthcare workforce. At least 50% of the funds must go to "Full-Service Partnership" (FSP) programs. FSPs are defined with conceptual and programmatic characteristics very similar to wraparound programs and include specific caseload ratio requirements. Beyond the FSP programs, funds are primarily intended for enhancing the existing system. All of these programs must focus on meeting the needs of the "unserved" and "underserved." Finally, throughout the MHSA legislation, one of the most consistent themes throughout is a very strong emphasis on the concept of "Recovery" to promote strength-based mental health treatment practices and to release service providers from Medicaid's deficit-based orientation.

Current Focus

This presentation focuses on a large-scale needs analysis focusing on data and feedback from consumers, family members, community representatives, and representative from collaborating agencies.

Methodolgy

Unmet Need

The most heavily weighted criterion used to make state-level decisions regarding allocation of MHSA funds was county-level estimates of the prevalence of "Serious Mental Illness," which is equivalent to the designation of "Seriously Emotionally Disturbed" more frequently referenced when discussing children's mental health services. County-level estimates were calculated based on population characteristics such as age, gender, and ethnicity.

While recognizing the limitations of these estimates, comparing data on local prevalence rates to data on the number of children receiving services results in an estimate of "unmet need," and unmet need estimates provide a basis for making comparisons to identify geographically distributed service disparities. Unmet need was aggregated based on geographic region and complex maps of data using GIS (Geographic Information Systems) software. Also, unmet need data were used to understand equity across children's mental health services in comparison with programs focusing on other age groups.

Qualitative, Community-Based Feedback

MHSA legislation explicitly required feedback from consumers, family members, community representatives, and representatives of other service providing agencies. Stakeholder input was integrated throughout the planning process and at all levels of the decision-making process.

As an example of the local processes used to collect qualitative data, results will be presented from Riverside County. With a population around